

Goals of Respite Care

- Reduce stress and help maintain family relations
- Assist and strengthen the family as a unit
- Contribute to good physical and emotional health and allow families to successfully continue caring for their children or adult family member at home
- Provide families time to rest, relax, and recreate
- Help families through periods of crisis and adjustment
- Help improve long-term family stability by reducing the need for out-of-home placements and lessening the need for long-term residential services



Respite Care Program

3800 E. Highway 34 – Hillsvie Plaza
c/o 500 E. Capitol Ave.
Pierre, SD 57501-5070

Phone: 800-265-9684
Fax: 605-773-7562
Website: dhs.sd.gov/dd/respite


Published by the South Dakota Department of Human Services
1,200 copies published at an approximate cost of 31 cents per copy

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Respite Care Program

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GIVING SOUTH DAKOTA'S CAREGIVERS A BREAK



South Dakota

DHS

DEPARTMENT OF HUMAN SERVICES

Division of Developmental Disabilities

Tel: (800) 265-9684

Web: dhs.sd.gov/dd/respite

▶ What is Respite Care?

Respite Care gives families a break from caring for a child or adult with disabilities. Providers, chosen by the family, care for children or adults with special needs while families take a class, go to a movie or go on a vacation. Families can do anything they enjoy during respite sessions. These breaks allow families time to tend to the needs of their other family members, spouses and themselves.

▶ Who is eligible?

- Any family having a child or adult with:
- a developmental disability,
 - developmental delay (birth to age 3),
 - serious emotional disturbance,
 - severe and persistent mental illness,
 - chronic medical condition (children),
 - a traumatic brain injury, or
 - a child they have adopted,
- may be considered for Respite Care.

The child or adult must be living in a family member's home. The family provides information indicating diagnosis and source of the diagnosis, or adoption status, to determine eligibility.

Each application will be reviewed by the Respite Care Program staff. Respite Care is available to qualifying families regardless of income.

▶ How does it work?

For an eligible child or adult, a family may receive up to \$550 of Respite

Care services, with \$200 for each additional eligible family member, up to a maximum of \$950 per family, per year (June 1–May 31). The family selects a provider and uses the Request For Payment form to purchase Respite Care services. The provider receives reimbursement by submitting the Request For Payment form to the Department of Human Services Respite Care Program.

▶ How do I apply?

Complete the attached application and return to the Respite Care Program. When the application is approved, you will receive a verification number, Request For Payment forms and additional information about the Respite Care Program.



Learn more

Tel: (800) 265-9684

Web: dhs.sd.gov/dd/respite

Respite Care application inside

APPLICATION FOR RESPITE CARE PROGRAM

(Please print or type)

PARENT/FAMILY MEMBERS NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ HOME PHONE: _____ WORK PHONE: _____

NAME OF CHILD OR ADULT WITH DISABILITY	DIAGNOSIS or Adoption Status	SOURCE of Diagnosis	DOB	SSN	IEP Y/N	R	S

The child or adult’s diagnosis and source of diagnosis must be listed above. **Documentation of the child’s or adult’s diagnosis, or adoption, must accompany this application form.** A copy of any document containing the diagnosis and name of the physician or therapist issuing the diagnosis should be sufficient for children or adults with a developmental disability, and children with developmental delays, or chronic medical conditions. If the child has a serious emotional disturbance, or the adult has a severe and persistent mental illness, a summary evaluation form available at dhs.sd.gov/dd/respite, or from the state Department of Human Services (1-800-265-9684) should also be completed by the therapist and returned with the application.

Family member’s relationship to child or adult with disabilities: _____

Are any of the children in your family adopted? _____ (yes or no)

Does your child or adult with disabilities reside in your home the majority of the year? ____ (yes or no) If no, please explain: _____

Briefly describe your family’s needs that could be met by the Respite Care Program due to your child or adult family member’s disability: _____

A qualifying family may receive services up to \$550 for one eligible child or adult per year, and \$200 for each additional eligible child or adult, up to a maximum of \$950 per year, per family. What amount of respite care do you request for your family for this year? _____

I understand for a child or adult to be eligible for the Respite Care Program they must have a developmental delay (children only) or disability, a serious emotional disturbance, a severe and persistent mental illness, a chronic medical condition (children only), traumatic brain injury or be adopted; and must reside within a family member’s home.

I hereby attest that my child(ren), or adult family member, meets the eligibility requirements for the Respite Care Program.

SIGNATURE _____

DATE _____

South Dakota Department of Human Services
3800 E. Highway 34 - Hillsvlew Plaza
c/o 500 E. Capitol Ave., Pierre, SD 57501-5070

(cut along dotted line)

Directions for Application

PARENT/FAMILY MEMBER’S NAME: Enter the name of the parent or family member with whom the person needing care resides. This person will be the contact for the S.D. Department of Human Services.

ADDRESS, CITY AND ZIP CODE: Enter the mailing address, city and zip code fore the above-named person.

HOME/WORK PHONE: Enter the home phone number for the above-named person. If it is OK to be contacted at work, also enter a work phone number.

NAME OF CHILD(REN) OR ADULT NEEDING CARE: Enter the full name of the child(ren) or adult needing care. Eligible care needs are defined as a developmental delay, developmental disability, a serious emotional disturbance, a severe and persistent mental illness, a chronic medical condition or a traumatic brain injury.

DIAGNOSIS or ADOPTION STATUS: Enter the child(ren)’s or adult’s diagnosis, or the child(ren)’s adoption status. For example: intellectual disability, attention deficit disorder, juvenile diabetes, etc.

SOURCE: Enter the name of the professional that determined the diagnosis. For example, psychologist, psychiatrist, therapist, physician. If you feel your child or adult family member is eligible, but do not have a diagnosis, call 1-800-265-9684 for further assistance.

DOB: Enter the child(ren)’s or adult’s date of birth.

IFSP/IEP Y/N: If the child(ren) is on an Individual Family Services Plan (IFSP) or Individual Education Plan (IEP), enter Y or yes. If the child(ren) is not on an IFSP or IEP, enter N or no.

RACE/SEX: Enter W for White, B for Black, H for Hispanic, AI for American Indian, AN for Alaskan Native, A for Asian or PI for Pacific Islander. Enter M for Male or F for Female. This information is optional and will be used for statistics and future program planning.

FAMILY MEMBER’S RELATIONSHIP TO CHILD OR ADULT NEEDING CARE: Identify relationship, e.g., mother, father, brother, sister, etc. Also identify if child or adult needing care is a foster child or adult in adult foster care.

DESCRIBE HOW YOUR CHILD OR ADULT’S NEEDS AFFECT HIM/HER AND YOUR FAMILY ON A DAILY BASIS: In a brief paragraph, describe the needs of child or adult and how they affect the child or adult family member and family.

AMOUNT OF RESPITE CARE REQUESTED: Within service/ dollar limits listed per child or adult, identify amount of respite care requested.